Bureau of Quality Improvement Services
Residential Services and Supports Survey

Individual whose Services are being Surveyed: _____ Social Security Number_____/_____/_____
Date of Survey: ____/____/_____ Time of Arrival: _____am pm Time of Departure: _____am pm

(Prepare data in items 1 through 26 prior to arrival at residence)

Address of Home:_____

Setting: ☐ Waiver 24/7 staffing ☐ Waiver less than 24/7 staffing ☐ Waiver residing with family ☐ State Line Item Only ☐ Foster Care Adult/Child

If on Waiver, check type of Waiver: ☐ Autism Waiver ☐ DD Waiver ☐ Support Services Waiver

Date of most recent Plan of Care: _____ Attach copy

Providers listed on Plan of Care/ISP:

Provider Name	Provider Contact Information	Services Authorized on Plan of Care/ICLB	Confirmed with CM?
_____	_____	_____	YES NO
_____	_____	_____	YES NO
_____	_____	_____	YES NO
_____	_____	_____	YES NO
_____	_____	_____	YES NO

BDDS Service Coordinator: _____ District #_____

Review Incident Report Database: Have any incidents been reported for this individual in the past year? ☐ yes ☐ no If yes, attach copy of each.

Review complaint database: Have any complaints been reported for this individual in the past year? ☐ yes ☐ no If yes, attach copy of each
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Review Targeted Case Manager 90 day reviews for past 12 months. Attach copy of each. Note any problems:_____

_____

.Lead Quality Coordinator _____ Second Quality Monitor/Coordinator _____

Lead Quality Coordinator is responsible for determining corrective action, assuring completion of data entry, filing of incident reports and follow up scheduling of this report)

INDIVIDUALIZED SUPPORT PLAN REVIEW

1. ISP current?	Yes No	Note any concerns:
2. Has facilitator completed training by an approved BDDS PCP training entity?	Yes No	Note any concerns:
3. Personal and Demographic Information completed?	Yes No	Note any concerns:
4. Emergency Contacts section completed?	Yes No	Note any concerns:
5. Person Centered Planning Profile available and indicates person centered planning process used?	Yes No	Note any concerns:
6. Desired Outcomes individualized and based on person centered planning process?	Yes No	Note any concerns:
7. Proposed activities/strategies individually developed and tie into Desired Outcome?	Yes No	Note any concerns:
8. Responsible party identified for each proposed activity/strategy?	Yes No	Note any concerns:
9. Time frame less than 12 months for each proposed activity/strategy?	Yes No	Note any concerns:
10. Statement of agreement signed and dated by individual/guardian?	Yes No	Note any concerns:
11. Support plan participants identified and provided copy of ISP?	Yes No	Note any concerns:

BEHAVIORAL SUPPORT PLAN REVIEW

12. Does individual have behavioral support services provider designated in ISP or have a behavior support plan?	YES NO (if no go to #27	Note any concerns:	Confirmed by on-site survey? Yes No
13. Does behavioral support plan define target behaviors? IAC 6-18-2 (b)	Yes No	Note any concerns:	Confirmed by on-site survey? Yes No
14. Is behavioral support plan based on functional analysis? IAC 6-18-2 (c)	Yes No	Note any concerns:	Confirmed by on-site survey? Yes No
15. Does behavioral support plan include written guidelines for teaching functional and useful replacement behaviors? IAC 6-18-2 (d)	Yes No	Note any concerns:	Confirmed by on-site survey? Yes No N/A
16. Does behavioral support plan use nonaversive methods for teaching functional and useful replacement behaviors? IAC 6-18-2 (e)	Yes No	Note any concerns:	Confirmed by on-site survey? Yes No N/A
17. Does behavioral support plan conform to ISP, including needs and outcomes identified in the ISP and ISP's specifications for behavioral support services? IAC 6-18-2 (f)	Yes No	Note any concerns:	Confirmed by on-site survey? Yes No
18. Does behavioral support plan include documentation system for direct care staff that includes all elements? IAC 6-18-2 (h)	Yes No	Note any concerns:	Confirmed by on-site survey? Yes No
19. Does behavioral support plan include assessing the use of medication and the appropriateness of a medication reduction plan or documentation that a reduction plan was implemented within the past 5 years and not effective? IAC 6-18-2 (i)	Yes No	Note any concerns:	Confirmed by on-site survey? Yes No
20. Is plan free of a highly restrictive procedure? (If Yes go to #26) IAC 6-18-2 (j)	Yes No	Note any concerns:	Confirmed by on-site survey? Yes No

21. If No, does plan contain a functional analysis of targeted behavior for which highly restricted procedure is designed? IAC 6-18-2 (j) (1)	Yes No N/A	Note any concerns:	Confirmed by on-site survey? Yes No
22. Documentation that risks of targeted behavior have been weighed against risks of highly restrictive procedure? IAC 6-18-2 (j) (2)	Yes No N/A	Note any concerns:	Confirmed by on-site survey? Yes No
23. Documentation that systemic efforts to replace targeted behavior with an adaptive skill were used and were not effective? IAC 6-18-2 (j) (3)	Yes No N/A	Note any concerns:	Confirmed by on-site survey? Yes No
24. Documentation that the individual, the support team, and the applicable human rights committee agree that the use of highly restrictive method is required to prevent significant harm to the individual or others. IAC 6-18-2 (j) (4)	Yes No N/A	Note any concerns:	Confirmed by on-site survey? Yes No
25. Informed consent from the individual or legal representative? IAC 6-18-2 (j) (5)	Yes No N/A	Note any concerns:	Confirmed by on-site survey? Yes No
26. Documentation that behavior support plan is reviewed regularly by the support team? IAC 6-18-2 (j) (6)	Yes No	Note any concerns:	Confirmed by on-site survey? Yes No

Upon arriving at the home, identify self as an Employee with the Bureau of Quality Improvement Services (provide ID card if requested) and state your purpose for visiting (i.e. to perform an annual provider survey for BQIS). The individual or legal representative has the right to refuse entry into the home.

Note any problems with being allowed into the home below, and notify supervisor before end of same business day. If no problems, enter "NA".

_____

Names & Positions of staff present:

_____ (Name / position)	_____ (Name / position)	_____ (Name / position)
_____ (Name / position)	_____ (Name / position)	_____ (Name / position)

27. Is home staffing correct at time of survey? (circle one) (Inquire if all staff scheduled are present) YES NO

INDIVIDUAL INTERVIEW SECTION

Individual is: ÿ **able to communicate answers to questions** ÿ **non-communicative**

- Communicate with the individual whenever possible. If the individual is non-communicative, indicate below the person acting as the main respondent by checking the appropriate selection:

paid caregiver ÿ family member ÿ guardian ÿ other ÿ (specify relationship to individual)_____

Individual Rights/Respect IAC 6-8-2, IAC 6-8-3, IAC 6-9-3

28. Do staff treat you with respect and ask you what you want when appropriate? (6-8-2), (6-8-3)	YES NO	Note any concerns:
29. Are you given choices on activities, including when you would like to go places? (6-8-2), (6-8-3)	YES NO	Note any concerns:
30. Do you have access to your personal possessions when staff is present? (6-8-2), (6-8-3)	YES NO	Note any concerns:
31. Do you have enough privacy in your bedroom and bathroom when staff is present? (6-8-2), (6-8-3)	YES NO	Note any concerns:
32. (ONLY TO BE ANSWERED BY INDIVIDUAL OR LEGAL REPRESENTATIVE) Are you satisfied with how your money is handled? Are financial issues being taken care of? Do you receive copies of the balanced checkbook monthly? (6-8-3)	YES NO N/A	Note any concerns:

33. This question is not to be asked in the presence of provider (ONLY TO BE ANSWERED BY INDIVIDUAL OR LEGAL REPRESENTATIVE) Are you satisfied with your providers? Do the people who help you treat you the way you want to be treated? (6-8-2), (6-8-3)	YES NO N/A	Note any concerns:
34. "Do you know who your Targeted Case Manager is? What is their name?" (6-19-6)	YES NO N/A	If yes, name of TCM given by individual/respondent:
35. "Has your Targeted Case Manager visited with you in the past 90 days?"(Can rephrase as "when did you last see your Targeted Case Manager?" Issue is - have they seen this person recently?) (6-19-6)	YES NO DON'T KNOW N/A	Confirm documentation of TCM presence in home and note. If documentation present, describe. If not present, note:
36. This question is not to be asked in presence of TCM: (ONLY TO BE ANSWERED BY INDIVIDUAL OR LEGAL REPRESENTATIVE) Are you satisfied with your case manager? Are all things being done the way you feel they should? (6-19-6)	YES NO N/A	Note any concerns:

		Does response present a concern?
(NOTE: For 37a, 37b & 37c - if individual is non-communicative make note to that effect and mark sections NA (caretaker will be questioned later in survey regarding these safety issues) 37. What do you do... " (6-29-6)	37. "If there is a fire"?	YES NO NA
	37. "If there is a tornado warning"?	YES NO NA
	37. "If you smell gas"?	YES NO NA

38. "What plans or activities does the staff help you with"? List activities provided in response: • • • • • • • • • • • (6-24-1 & 2)	List additional plans/activities as included in the record: • • • • • • • • • • •	Compare to ISP and note any concerns:

HEALTH CARE COORDINATION:

39. Is there a provider identified as responsible for health care coordination in the ISP? **NOTE: IF INDIVIDUAL OR FAMILY MEMBER IS RESPONSIBLE FOR HEALTH CARE COORDINATION THEN GO TO QUESTION #52 (6-25-1)**	YES NO	If yes, who is the provider or family member?
40. "Do you have medical records or documentation pertaining to your medical treatment?"	YES – records are available NO – records unavailable	List all concerns, including details on "NO" response:
40a. If yes, "may I look at them?" (6-17-3; 6-25-3)	YES – may see records NO – may not see records	
41. "Have you had any emergency medical treatment in the past year?"	YES – had ER treatment NO – did not have ER treatment	List all concerns, including details on "NO" response:
42. If yes, "did you receive proper follow-up care?" (confirm by reviewing documentation) (6-25-3)	YES – had proper follow-up NO – did not receive needed follow-up N/A	
43. "Did you have a physical exam in the past year?" (6-25-2)	YES NO	List all concerns, including details on "NO" response:
44. "Did you have a dental exam in the past year?" (6-25-2)	YES NO	List all concerns, including details on "NO" response:

45. "Are all your medical conditions monitored and followed up as recommended or prescribed by your physician?" (6-25-3)	YES NO	List all concerns, including details on "NO" response:	
46. "Do you take medication?" 47. If yes, "do you give yourself your medication, or does someone give it to you?" (6-25-3 & 4)	YES NO Self-Medicates Someone else Administers N/A	List all concerns:	Agrees with ISP? Yes No
48. If someone else administers medication, is there documentation for the date/time given with initials by the person who administered it, and is it problem free, i.e. no blank spaces, no errors etc? (review documentation) (6-25-4)	YES NO N/A	List all concerns, including details on "NO" response:	
49. "What medications do you take?" (confirm information obtained with medication sheets) (6-25-3 & 4)	LIST ALL MEDICATIONS:		
50. "Do you have a history of seizures?" (6-25-3 & 4)	YES NO	50a. If # 50 "YES", do you take medication to control your seizures?	YES NO
		50b. If 50 "YES", Do you have a seizure disorder / epilepsy diagnosis?	YES NO
51. If yes, does seizure management system include the following elements? (6-25-7)	Staff training on medication administration? Documentation of events immediately preceding, during and following a seizure? Documentation of physician follow-up and follow along services? Individual's levels of seizure mediation checked annually or as ordered by physician? Information on seizures provided to all providers?		YES NO YES NO YES NO YES NO YES NO
52. IF INDIVIDUAL/FAMILY MEMBER IS RESPONSIBLE FOR HEALTH CARE COORDINATION: Do you have any concerns with your health care needs or feel you need additional support? If yes, what are they and have you discussed these with your case manager?	Note response:		

Safety and Environmental Requirements

53. Is there a provider designated as responsible for providing environmental and living arrangement support in the ISP? NOTE: IF THIS IS THE INDIVIDUAL OR FAMILY MEMBER, ONLY ASK QUESTION #54 and #55. 6-29-1	YES NO	**Name of provider/individual or family member**

Request permission from individual before touring the residence. Best practice is the individual providing a tour of the home to assess the environment for health and safety issues.

Use these guidelines to review the interior and exterior of the home:

- Cleanliness of area related to risk of infection/disease
- Adequate heating and cooling
- Furnishings meet the needs of the individuals
- Minimal use of extension cords
- No frayed cords; empty light sockets, burned out or bare lightbulbs
- General maintenance – home is in good condition – holes patched, etc.
- Free from foul odors, insects and rodents;
- Cleaning and food items are stored properly
- Appliances and fixtures in working order
- No exposed wiring – including absence of outlet covers
- No window coverings that pose a danger to the individual (ex - cords from blinds that hang on the bed)

54. If individual/family member is responsible for environmental and living arrangement supports," are there any significant health and safety issues identified in the home?"	YES NO N/A	Note any concerns:
55. Are there any environmental or living arrangement supports that you would like additional support on or that you are concerned with? GO TO QUESTION # 65	Note response:	

<table>
<tr><td rowspan="5">56. Is this home's interior and exterior free of any health and safety concerns (real risks for injury, infection, disease, etc.)?

If "NO" describe the specific issue, and provide specific details of each concern.

(6-29-2)</td><td rowspan="5">YES

NO</td><td>Specific health/safety concern observed</td><td colspan="2">Detailed, specific reason/s this issue is being identified as risk to health and safety:</td></tr>
<tr><td>1.</td><td colspan="2">1.</td></tr>
<tr><td>2.</td><td colspan="2">2.</td></tr>
<tr><td>3.</td><td colspan="2">3.</td></tr>
<tr><td>4.</td><td colspan="2">4.</td></tr>
<tr><td>57. Are all areas of the home accessible to the individual with unlimited access?

(6-8-2)</td><td>YES

NO</td><td colspan="3">If "NO", describe in detail – include specifics including any documentation in the Individualized Support Plan of any limited access:</td></tr>
<tr><td>58. Are emergency numbers available for the police, fire and ambulance (911), the individual's legal representatives, the local BDDS office, the individual's case manager, adult protective services, and the DD waiver ombudsman in an area visible from the telephone used by individual or as indicated in ISP? (6-29-8)</td><td>YES
NO</td><td colspan="2">Note any concerns:</td><td>Conforms with ISP?
YES
NO</td></tr>
<tr><td>59. Is the food present congruent with the individual's diet needs as indicated in ISP? Ask permission before looking in cabinets. (i.e. –is there food appropriate for a diabetic diet if necessary, soft foods for a person without teeth, etc.)
(6-26-1)</td><td>YES
NO</td><td colspan="3">Note any concerns:</td></tr>
</table>

60. Are all medications stored separately, locked, and according to medication requirements (i.e. – refrigerated if necessary) and dispensed from the original container or as indicated in the ISP? (6-25-4)	YES NO	Note any concerns:
61. Is all adaptive equipment as indicated in the ISP or other documentation available and meeting the needs of the individual? (glasses, hearing aids, communication devices, mobility aides, eating utensils, etc. – are they working properly and does the individual and/or staff know how to utilize them?) (6-32-2)	YES NO N/A	Note any concerns:
62. Is there a working smoke alarm (one that meets the individual's needs i.e. – visual alarm for individuals who are deaf, etc.) located in areas considered appropriate by local fire marshal (6-29-4) NOTE: Test the alarm/s after asking permission to do so. Only the individual or family can deny permission.	YES NO	Note any concerns:
63. Is there a fire extinguisher in the home that appears to be in working order and is checked annually? (6-29-4)	YES NO	Note any concerns:
64. Is tap/bath water maximum temperature 110 degrees Fahrenheit or less if noted as a need in the ISP? (6-29-4)	YES NO	Note any concerns:

Review of Documentation

65. Is there a current ISP in the home (less than 12 months old?	YES NO	Date of Plan:
66. Is it identical to ISP reviewed before survey?	YES NO	Date of Plan:

Does the Individualized Support Plan identify a need in the area of:		If yes, documentation confirms all supports in place?	If no, is there documentation that indicates there may be a need?	Describe all "NO" responses in "Documentation confirms all supports in place?" column or describe any "YES" responses in "Documentation that indicates there may be a need":
67. Seizure management	YES NO	YES NO NA	YES NO NA	
68. Allergies	YES NO	YES NO NA	YES NO NA	
69. Uses or Requires Dentures	YES NO	YES NO NA	YES NO NA	
70. Chewing difficulties	YES NO	YES NO NA	YES NO NA	
71. Swallowing difficulties	YES NO	YES NO NA	YES NO NA	
72. Dining difficulties	YES NO	YES NO NA	YES NO NA	
73. Vision difficulties	YES NO	YES NO NA	YES NO NA	
74. Hearing difficulties	YES NO	YES NO NA	YES NO NA	
75. Speaking difficulties – mode of communication	YES NO	YES NO NA	YES NO NA	
76. Behavior issues	YES NO	YES NO NA	YES NO NA	
77. Issues discovered through incident reporting	YES NO	YES NO NA	YES NO NA	
78. Medication/self medication issues	YES NO	YES NO NA	YES NO NA	
79. Lab testing	YES NO	YES NO NA	YES NO NA	
80. Chronic conditions	YES NO	YES NO NA	YES NO NA	

81. Water Temperature Safety	YES NO	YES NO NA	YES NO NA	
82. Dentist	YES NO	YES NO NA	YES NO NA	
83. Specialists	YES NO	YES NO NA	YES NO NA	
Are there other documents (POC, assessment, etc.) that identify a need in the area of:		Documentation confirms all supports in place?	Describe any item marked "Unclear". Describe any "NO" response in "Documentation confirms all supports in place?" column:	
84. Health Care Coordination (6-17-3)	YES NO Unclear	YES NO NA		
85. Specialist (6-17-3)	YES NO Unclear	YES NO NA		
86. Vision care (6-17-3)	YES NO Unclear	YES NO NA		
87. Dental care (6-17-3)	YES NO Unclear	YES NO NA		
88. Regular physician (6-17-3)	YES NO Unclear	YES NO NA		
89. Annual physicals (6-17-3)	YES NO Unclear	YES NO NA		
90. Adaptive equipment (6-17-3)	YES NO Unclear	YES NO NA		
91. Psychiatrist (6-17-3)	YES NO Unclear	YES NO NA		
92. Is there 60 days of documentation by all providers that includes: • Date and amount of time spent with individual • Location of services (if outside of the home) • Type of Services • Description of activities • Signature of Staff who provided services (6-17-3)		YES NO	Note any concerns:	

93. Is the documentation and environment free of any evidence that a reportable incident may not have been reported? (6-9-5)	YES NO	**Incident report stating "The following reportable items were seen during a BQIS Survey" required for all "NO" answers.** Provide the details of the reportable incident both here and in Incident Report:
94. Is there documentation of ISP outcomes and progress made toward achieving those outcomes present? (6-17-3)	YES NO	Note any concerns:

Staff Interview Section

		Record specifics of staff response. "YES" marked only for competent, correct responses:	Note any concerns:
95. "Do you know what universal precautions are? Please tell me how you utilize them on the job". (i.e. – what steps do you take if you need to clean up blood)? (6-14-4)	YES NO		
96. "Are you familiar with the signs and symptoms of seizure activity, including any aura prior to a seizure? What are they"? (6-14-4)	YES NO		
97. "How would you document a seizure?" Ask specifically and view the documentation to assure that documentation includes activity before, during and after the seizure. (6-25-7)	YES NO		
98. "Do you know the individual's diet needs, including how to prepare their food? Please tell me about the individual's diet needs." (6-14-4)	YES NO		
99. "Are you aware of possible side effects of the individual's medication? What are they?" NOTE: "NA" only if on no medications (6-25-6)	YES NO N/A		

100. "Have you been trained in the individual's behavior management plan? What are the targeted behaviors and interventions used?" NOTE: "NA" only if no behavior plan in the ISP (6-14-4; 6-18-2)	YES NO N/A		
101. "If manual restraints are used, have you had training in non-injurious aggression management techniques?" NOTE: "NA" only if on no manual restraints used and/or none in ISP. (6-18-2)	YES NO N/A		
102. "Do you know how to report an incident per the BDDS incident reporting procedure?" **(Includes knowing the types of reportable incidents and knowledge that they have the ability to independently report incidents to APS/CPS.)** (6-9-5)	YES NO		

103. "What do you do…..": (staff should be able to state how to exit/take shelter, along with precautions to take and who to contact) Response is not competent if the staff indicates that they would phone for emergency assistance prior to leaving the home for fire or smelling gas. (6-14-4)	a. "If there is a fire?" (document response)	Does response present a concern? YES NO
	b. "If there is a tornado warning?" (document response)	YES NO
	c. "If you smell gas (NA only if there is no gas utility service connected to the home?" (document response))	YES NO N/A

Questions in this section are addressed to and should be answered by the BQIS staff person performing this survey:		
104. Is this visit and survey free of any observed or evidence of abuse, neglect or exploitation?	YES NO	If "NO", file an incident report. Make decision on need to implement the BQIS IMINENT DANGER POLICY based on facts. Contact supervisor and provide update on filing of incident report, any other policy implementation, and get consensus on appropriate immediate action. Summarize findings and actions taken:
105. Is this visit and survey free of any observed heath or safety concerns for this individual not documented in the questions listed above that do not meet the BDDS Incident Reporting criteria? (not serious enough to require an incident report or implementation of imminent danger policy)	YES NO	If "NO", describe in detail:

Survey summary – Corrective Action plans vs. concerns needing attention

For each item in survey identified with a concern, indicate appropriate action needed by service provider in tables below

Survey items requiring follow-up by BQIS

Item #	Brief description of concern & recommended method of confirming compliance (ex. re-visit home; receipt of verification documents; etc)	provider

Survey items requiring informal attention by provider

Item #	Brief description of concern	provider

Surveyor signature

"I attest that this survey is an accurate account of findings based on my observations on the date and time indicated"

Lead Surveyor; _____ _____ _____

Signature Title Date Signed

For additional notes, attach sheets/documents as necessary